

REHAB ACTION, INC

Invoice

Therapist's Name: _____ **Week:** _____

Patient Name	Company	SUN	M	T	W	Th	F	SAT	NOTES
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Invoices must be emailed by 9am every Monday to rehabactioninc@gmail.com

REMEMBER: Check your home page for pending or needs corrections visits. Only completed approved visits will be paid.

TX = TREATMENT MV= MISSED VISIT E = EVAL RA=REASSESSMENT DC = DISCHARGE
SOC = START OF CARE OASIS RC = RECERT OASIS ROC = RESUMPTION OF CARE OASIS